MEDMUTUAL LIFE®
A Medical Mutual Company

100 American Road
Brooklyn, OH 44144-2322

PARTICIPATION AGREEMENT

Please Type or Print All Information

Group Number

PART 1: APPLICANT INFORMATION

1. Name of Policyholder Insurance Trust for Michigan Public Entities (000008)			Check if applicable: ☐ Partnership ☐ LLC ☐ Subchapter S Corp. ☐ Sole Proprietorship
2. Participating Employer (legal name)			
3. Participating Employer Mailing Address (not P.O. Box)			
Participating Employer Contact		Phone ( )	
City	State	Zip	Fax ( )
4. Name of any ☐ Affiliates ☐ Subsidiaries to be covered			e-mail
5. Nature of Business			6. SIC Code

LIFE, ACCIDENTAL DEATH & DISMEMBERMENT, DEPENDENT LIFE AND SHORT-TERM DISABILITY

☐ Yes, I am electing life and/or short-term disability coverage in accordance with proposal number _____, incorporated by reference in and made part of this Participation Agreement for all purposes.
If multiple plans are indicated on the proposal, indicate plan option elected _____.

The requested effective date will be as stated in the above-mentioned proposal, unless indicated below:

_____.

Participation-free coverage

☐ Yes, I am electing participation-free Voluntary Life and AD&D
☐ Yes, I am electing participation-free Voluntary Life, AD&D and short-term disability.
If participation-free, voluntary short-term disability is elected, indicate the plan: ☐ 1/8/13 ☐ 1/8/26

Waiting period is identical to medical probationary period, unless indicated below:
☐ None
☐ First of month following completion of _____ days
☐ Other _____

Employees working less than **20 hours** per week are not eligible for coverage. If different than 20 hours, please indicate number of hours: _____

Employer contribution percentages (%) for all products are as stated in the proposal, unless indicated below:

Product	%	Product	%
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

GROUP LONG-TERM DISABILITY

☐ Yes, I am electing group long-term disability coverage in accordance with proposal number _____, incorporated by reference in and made part of this Participation Agreement for all purposes.
If multiple plans are indicated on the proposal, indicate plan option elected _____.

The requested effective date will be as stated in the above-mentioned proposal, unless indicated below:

_____.

Prior carrier:
(Prior carrier must be listed and a copy of the prior policy included for **continuity of coverage** to apply.)

Termination date of prior policy: _____

Waiting period – present employees: _____

Waiting period – future employees: _____

Employees working less than 30 hours per week are not eligible for coverage. If different than 30 hours, please indicate number of hours: _____ .

Contribution:

Employer _____% Employee _____% ☐ Pre-tax dollars ☐ Post-tax dollars

TERMS AND CONDITIONS

The above information is true and accurate to the best of my knowledge. I understand that the information on this Participation Agreement and any other information I provide shall serve as the basis for the coverage to be issued, and that I have a duty to notify MedMutual Life Insurance Company of any changes. I have relied upon no oral or written representations that contradict item (1) above.

I, as the undersigned employer or other eligible membership organization ("Participating Employer"), hereby apply for coverage under the group insurance policy offered by MedMutual Life Insurance Company (MedMutual Life) to the policyholder named in Part 1 of this Participation Agreement. I acknowledge that a copy of the group insurance policy is available at the policyholder's office for review by Participating Employers and employees. I acknowledge that no coverage can commence unless I receive written notice from MedMutual Life's home office.

I agree that, upon acceptance and approval by MedMutual Life, I will, so long as such participation continues, fully comply with all obligations applicable to Participating Employers under the policy, as set forth therein. I understand that the insurance coverages under the group insurance policy will be only as provided for under the policy issued to the policyholder. I acknowledge that the policyholder is not an insurer, and has no obligations regarding payment of premiums or handling of claims for the insurance provided under the group insurance policy issued to it as policyholder.

I understand that this insurance is subject to the approval of MedMutual Life, and nothing contained herein shall be binding upon MedMutual Life until this application is approved and accepted at MedMutual Life's home office. No waiver or change will bind MedMutual Life unless signed by Executive Officer of MedMutual Life.

I certify that the information in this Participation Agreement is true and accurate to the best of my knowledge. I understand that the information in this Participation Agreement and any other information I provide shall serve as the basis for coverage to be issued, and that I have a duty to notify MedMutual Life of any changes. I have relied upon no oral or written representations that contradict the aforementioned active-work information.

_____ _____
Participating Employer Name Date

_____
Participating Employer Signature

_____
Title

NOTE: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties as determined by a court of competent jurisdiction.